



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MEMORIAL HERMANN HOSPITAL
3200 S.W. FREEWAY, STE 2200
HOUSTON, TX 77027

Respondent Name

HIGHLANDS INSURANCE CO

Carrier's Austin Representative Box

Box Number 01

MFDR Tracking Number

M4-08-3469-01

MFDR Date Received

JANUARY 22, 2008

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Since the insurance carrier did not conduct an in-house or desk audit on these medical expenses, Requestor submits that a fair and reasonable rate for surgeries performed on this employee are the usual and customary charges incurred."

Amount in Dispute: \$37, 857.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider has not shown that it should be paid at a fair and reasonable rate, what the fair and reasonable rate would be if it were entitled to be paid at a fair and reasonable rate, or why it should not be reimbursed pursuant to Division Rule 134.401 at the per diem rate of reimbursement plus an additional amount for implants."

Response Submitted by: Beverly L. Vaughn, Attorney-At-Law, 5501-A Balcones Dr. #104, Austin, TX 78731

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
January 22, 2007 to January 24, 2007	Outpatient Hospital Services	\$37,857.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

- 16-Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided \$0.00
- 647-002- Reimbursement has been calculated based on a percentage of the charges.
- 855-022-Charge denied due to lack of sufficient documentation of services rendered \$0.00
- W1- Workers Compensation State Fee Schedule Adjustment
855-002- Recommended allowance is in accordance with Workers Compensation Medical Fee Schedule Guidelines. \$0.00 \$1,118.00
- 45-Charges exceed your contracted/legislated fee arrangement.
- W1- Workers Compensation State Fee Schedule Adjustment.
- 855-002-Recommended allowance is in accordance with Workers Compensation Medical Fee Schedule Guidelines. \$0.00
- 855-002-Recommended allowance is in accordance with Workers Compensation Medical Fee Schedule Guidelines. \$2,236.00
- 855-002-Recommended allowance is in accordance with Workers Compensation Medical Fee Schedule Guidelines. \$8,415.00
- W1-Workers Compensation State Fee Schedule Adjustment \$0.00
- W1- Workers Compensation State Fee Schedule Adjustment \$2,236.00
- Workers Compensation State Fee Schedule Adjustment \$8,415.00
- W3-Additional payment made on appeal/reconsideration.

Findings

1. The insurance carrier reduced or denied disputed services with reason code 45 – “Charges exceed your contracted/legislated fee arrangement.” Review of the submitted information finds insufficient documentation to support that the disputed services are subject to a contractual agreement between the parties to this dispute. The above denial/reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. This dispute relates to services with reimbursement subject to the provisions of Texas Administrative Code §134.1, effective May 2, 2006, 31 *Texas Register* 3561, which requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers’ compensation health care network shall be made in accordance with subsection §134.1(d) which states that “Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available.”
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual’s behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. 28 Texas Administrative Code §133.307(c)(2)(G), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable.” Review of the submitted documentation finds that:
 - The requestor’s position statement asserts that “Since the insurance carrier did not conduct an in-house or desk audit on these medical expenses, Requestor submits that a fair and reasonable rate for surgeries performed on this employee are the usual and customary charges incurred.”
 - The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services.
 - The Division has previously found that “hospital charges are not a valid indicator of a hospital’s costs of providing services nor of what is being paid by other payors,” as stated in the adoption preamble to the Division’s former *Acute Care Inpatient Hospital Fee Guideline*, 22 *Texas Register* 6276. It further states that “Alternative methods of reimbursement were considered... and rejected because they use hospital charges as their basis and allow the hospitals to affect their reimbursement by inflating their charges...” 22 *Texas Register* 6268-6269. Therefore, the use of a hospital’s “usual and customary” charges cannot be favorably considered when no other data or documentation was submitted to support that the payment

amount being sought is a fair and reasonable reimbursement for the services in dispute.

- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

Authorized Signature

_____ Signature	_____ Medical Fee Dispute Resolution Officer	<u>09/28/2012</u> Date
_____ Signature	_____ Medical Fee Dispute Resolution Manager	<u>09/28/2012</u> Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.